

Claimant Name:
Reference Number:

Job Analysis for Self – Employed Workers

Business Name:	
Business Address:	
Business Phone Number:	
Date Business Opened:	
Sole ownership or partnership:	
Nature of Business:	
Regular work hours per day/week:	
Last day worked at Business:	
Estimated return to work date: (full-time or part-time)	
Is your business still in operation?	<p>If yes, please outline what duties you are still performing, including hours per day and per week worked.</p>
	<p>If no, who is performing your duties in your absence?</p>
Are you in receipt of any wages or profit from your business since your last day worked?	



Creditor Insurance Office-Toronto
330 University Avenue
Toronto ON M5G 1R8

Fax No.: 416-552-6557

Claimant Name:
Reference Number:

Please provide the following details of your business:

- **Environment** - Temperature, Light, Noise, Vapour/Fumes, Physical Hazards, etc.):
- **Equipment** - Types of machines, equipment, tools and work aids required to perform occupation:
- **Vehicles** – Vehicles or equipment driven at work: Please specify if a special license is required.
- **Job Modifications:** Can job duties and work hours be modified to accommodate your restrictions? If not, please explain why?
- **Workplace Modifications:** What physical aids can be provided to accommodate a return to work?
- **Loss:** Please describe any profit losses or operating costs your business has incurred since your disability began. Have you liquidated any assets? Have you declared bankruptcy?

Fax No.: 416-552-6557

Claimant Name:
Reference Number:

Physical Demands of your occupation at the time of disability
Please circle the appropriate numbers below for each Job requirement

- 0 - never performed
- 1 - sometimes performed
- 2 - performed occasionally, less than 1 hour per day
- 3 - frequent and/or repetitious for 1-3 hours daily
- 4 - maximum job requirement for over 3 hours per day

Sitting Chair	0	1	2	3	4	Gripping	0	1	2	3	4
Sitting Vehicle Seat	0	1	2	3	4	Pinching	0	1	2	3	4
Standing	0	1	2	3	4	Typing	0	1	2	3	4
Walking:						Climbing:					
Level Surface	0	1	2	3	4	Ladders	0	1	2	3	4
Uneven Surface	0	1	2	3	4	Scaffolding	0	1	2	3	4
Stairs	0	1	2	3	4	Other	0	1	2	3	4
Bending:						Lifting:					
Stooping	0	1	2	3	4	From Ground	0	1	2	3	4
Crouching	0	1	2	3	4	From Waist	0	1	2	3	4
Kneeling	0	1	2	3	4	Above Waist	0	1	2	3	4
Mobility:						Lifting, Carrying, Pushing, Pulling					
Carrying	0	1	2	3	4	0 to 10lbs	0	1	2	3	4
Pushing	0	1	2	3	4	10 to 25lbs	0	1	2	3	4
Pulling	0	1	2	3	4	25 to 50lbs	0	1	2	3	4
Crawling	0	1	2	3	4	over 50lbs	0	1	2	3	4
Reaching:											
Below Shoulder	0	1	2	3	4						
At Shoulder level	0	1	2	3	4						
Above Shoulder	0	1	2	3	4						

Comments:

Date: _____

Signature _____